

# CITY OF TEMPE BENEFITS ENROLLMENT/CHANGE FORM

(July 1- June 30)

Revised 7/17/02

<b>PERSONAL INFORMATION</b>				(Office use only)	
<input type="checkbox"/> <b>Dependent Change</b> <input type="checkbox"/> <b>Plan Change</b>		<input type="checkbox"/> <b>Qualifying Event</b> <input type="checkbox"/> <b>New Enrollment</b>		<input type="checkbox"/> <b>Beneficiary Change</b>	
Emp Last Name _____ Address _____ Apartment # _____		First Name _____ MI _____ City _____ State _____ Zip _____		SSN _____ Effective Date: _____ Date of Hire _____	
Home Phone _____		Work Phone _____		Marital Status _____ Sex _____ Spouse employed with City of Tempe: Yes <input type="checkbox"/> No <input type="checkbox"/>	

## COVERAGES

<b>MEDICAL</b> <input type="checkbox"/> PPO <input type="checkbox"/> Basic <input type="checkbox"/> CIGNA HMO <input type="checkbox"/> Waive Medical ( only available to Part-Time emps)  <b>LEVEL of COVERAGE</b> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Emp/Domestic Partner <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Emp/Dom.Partner/Child(ren) <input type="checkbox"/> Employee/Family	<b>DENTAL</b> <input type="checkbox"/> Metlife High Option <input type="checkbox"/> Metlife Low Option <input type="checkbox"/> Cigna Dental <input type="checkbox"/> No Dental  <b>LEVEL OF COVERAGE</b> <input type="checkbox"/> Employee only <input type="checkbox"/> Emp + 1 dependent <input type="checkbox"/> Emp + Domestic Partner <input type="checkbox"/> Emp + 2 or more dependents <input type="checkbox"/> Emp + 2 or more (incl Dom Partner)	<b>VISION</b> <input type="checkbox"/> Vision Service Plan <input type="checkbox"/> No Vision  <b>LEVEL OF COVERAGE</b> <input type="checkbox"/> Employee only <input type="checkbox"/> Emp + 1 dependent <input type="checkbox"/> Emp + Domestic Partner <input type="checkbox"/> Emp + 2 or more dependents <input type="checkbox"/> Emp + 2 or more (incl Dom Partner)
<b>Dependent Care Spending Account</b> (Thru Dec 31 of current year) <input type="checkbox"/> No <input type="checkbox"/> Yes Deduction per paycheck \$ _____ Annual Amount \$ _____ (Maximum \$5000 per year, \$2500 if married filing separately)		<b>Health Care Reimbursement Account</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Complete Sheakley Enrollment Form (Maximum \$2000 per year)
<b>VOLUNTARY LIFE</b> <input type="checkbox"/> Enroll in Voluntary Life. Complete forms in Ing/Reliastr packet. <input type="checkbox"/> Cancel or decrease Employee Voluntary Life to \$ _____ <input type="checkbox"/> Cancel or decrease Spouse Voluntary Life to \$ _____ <input type="checkbox"/> Cancel Child Voluntary Life		<b>VOLUNTARY AD&amp;D</b> <input type="checkbox"/> Employee Only Amount \$ _____ <input type="checkbox"/> Employee/Family (\$25k-\$500k in \$25k increments) <input type="checkbox"/> Employee/Children <input type="checkbox"/> None

**\*\*List all dependents to be enrolled. \*\***

Last/First/MI	SSN	Date of Birth	Sex	Add/Drop	Coverages	Cigna Medical Physician I.D	Cigna Dental Office Number
Employee					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Spouse					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Domestic Partner (Affidavit required)					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Dependent 1					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Dependent 2					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Dependent 3					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		

### For Office Use Only:

Effective Date: _____	Benesight: 2714 001	Cigna HMO: 3203768 ACT	MetLife: 100729 / SUB 001/Low or 002/High Mbr Cov Code: 1 (single) 8 (1 dep) 4 (2 deps)
Keyed: _____ COBRA Init: _____		Sent: Benesight _____ CIG HMO _____ CIG Dent _____ Met _____ DCSA _____ Sheakley _____ ING _____	

**Please turn this form over. Complete information on back, sign and date the form before returning to Human Resources.**

## QUESTIONS??? CALL 350-8576 OR 350-8080

**BENEFICIARY INFORMATION (Basic Life, Basic AD&D, Voluntary Life, Voluntary AD&D, Commuter AD&D)**

--

Primary _____ % _____	Relationship _____
_____ % _____	Relationship _____
Contingent _____ % _____	Relationship _____
_____ % _____	Relationship _____
Signature _____	Date _____

### AUTHORIZATION

I hereby apply for group benefits provided under the City of Tempe's group plan(s) and authorize payroll deductions, if required, for the cost of coverage. I understand that deductions for medical, dental, and vision are on a pre-tax basis unless I specify otherwise in writing to the Human Resources Department. These elections will remain effective until revoked by a subsequent election in writing. Participation in the HealthCare Reimbursement Account and Dependent Care Flexible Spending Account requires annual re-enrollment. Under penalty of perjury, by my signature below, I swear and affirm that all representation as to myself, dependents, and spouse are true and correct.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### WAIVER OF COVERAGE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

The Group Insurance benefits available through my employer have been explained to me and I understand the scope of the benefits. I reject the coverage for myself and/or my dependents and elect not to participate. I understand that if I reject this coverage I may subsequently enroll for coverage only through open enrollment or within 30 days of a qualified change in family status as described above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### NOTES:

- All benefits (except Dependent Care Spending Account) are on a July 1 – June 30 basis. Your next opportunity to change medical, dental and vision elections will be in the spring for a July 1 effective date.
- All employees complete Type of Change section
- If you are electing benefits for the first time, complete all sections.
- If you are changing your benefit elections, complete the Personal Information section and any other sections where a change is being made. (IMPORTANT: Include appropriate documentation of why change is being requested: birth certificate, marriage certificate, divorce decree, proof of loss of coverage, etc.). **Form must be received in Employee Benefits within 30 days following the qualifying event.**
- Your election for the Dependent Care Spending Account is for a **CALENDAR YEAR (January 1 – December 31)**. Please estimate your child care expenses through December 31 of the current year only. You will be given the opportunity to re-enroll in the fall for the upcoming year.
- If you are changing your beneficiary only, complete the Personal Information section and the Beneficiary Information section.
- If you are enrolling a dependent child age 19 or over, include documentation of full-time student status or proof of mental/physical handicap.
- If enrolling Domestic Partner completion of Domestic Partner Affidavit is required, along with supporting documentation.
- Sign and date the form. Return to Employee Benefits.

### INFORMATION REGARDING DOMESTIC PARTNERSHIP COVERAGE

In addition to all other rules and conditions of city insurance coverage, the following apply to domestic partners coverage:

In order for an employee to enroll a domestic partner for insurance coverage, both the employee and the domestic partner must complete the Domestic Partnership Affidavit.

The portion of the insurance premium paid by the employee for domestic partner and children of the domestic partner is paid on an after-tax basis. The portion of the premium paid by the City for domestic partner and children of the domestic partner is reported to the Internal Revenue Service as taxable income to the employee. City employees who have domestic partnership insurance coverage are required to complete a Termination of Domestic Partnership form within 30 days of the termination of the domestic partnership. **Children of a domestic partner may enroll for coverage only if the domestic partner is enrolled for coverage.**